Chapter 5 Billing on the CMS 1500 Claim Form



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Fee-For-Service Provider Manual Chapter 5

September 2008 Page: 5 - 1

INTRODUCTION

The CMS 1500 claim form is used to bill for most non-facility services, including professional services, transportation, and durable medical equipment. Ambulatory surgery centers and independent laboratories also must bill for services using the CMS 1500. CMS-1500 (08/05) version became effective 1/1/2007. Effective April 2, 2007, AHCCCS will accept only this revised version. Minor changes have been made to the form in order to accommodate the National Provider Identifier (NPI) as well as current identifiers for a transition period until NPI is implemented. In order to distinguish this version from the previous versions, the 1500 symbol and the date approved

(08/05) by NUCC has been added to the top margin of the claim form.

- ☑ CPT and HCPCS procedure codes must be used to identify all services.
- ☑ ICD-9 diagnosis codes are required.
 - ✓ AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.

COMPLETING THE CMS 1500 CLAIM FORM (VERSION (08/05))

The following instructions explain how to complete the CMS 1500 claim form (08/05) and whether a field is "Required," "Required if applicable," or "Not required."

NOTE: This chapter applies to paper CMS 1500 claims submitted to AHCCCS. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide. Companion documents for 837 transactions are available on the AHCCCS Web site at www.ahcccs.state.az.us. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

1.	Carrier Block	Required
	The carrier block is located in the upper right margin of the form.	

Check the second box labeled "Medicaid."

MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP	FECA	OTHER
				HEALTH PLAN	BLK LUNG	
(Medicaret)	(Medicaid#)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	\square (ID)

Fee-For-Service Provider Manual

Billing on the CMS 1500 Claim Form

Page: 5 - 2 Chapter: 5



COMPLETING THE CMS 1500 CLAIM FORM (VERSION 08/05)(CONT.)

1a. Insured's ID Number

Required

Enter the recipient's *AHCCCS ID number*. If there are questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit. (See Chapter 2, Recipient Eligibility and Enrollment). Behavioral health providers must be sure to enter the client's AHCCCS ID number, *not* the client's BHS number.

1a. INSURED'S ID NUMBER (FOR PROGRAM IN ITEM 1)

A12345678

2. Patient's Name Required

Enter recipient's last name, first name, and middle initial as shown on the AHCCCS ID card.

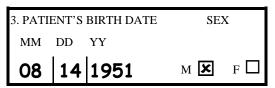
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

Smith, John H.

3. Patient's Date of Birth and Sex

Required

Enter the recipient's date of birth. Check the appropriate box to indicate the patient's gender.



4. Insured's Name Not required

5. Patient Address Not required

6. Patient Relationship to Insured Not required

7. Insured's Address Not required



Fee-For-Service Provider Manual

September 2008

Chapter: 5 Page: 5 - 3

8. Patient Status Not required

COMPLETING THE CMS 1500 CLAIM FORM (VERSION 08/05)(CONT.)

9. Other Insured's Name

Required if applicable

If the recipient has no coverage other than AHCCCS, leave this section blank. If other coverage exists, enter the name of the insured. If the other insured is the recipient, enter "Same."

9a. Other Insured's Policy or Group Number

Required if applicable

Enter the group number of the other insurance.

9b. Other Insured's Date of Birth and Sex

Required if applicable

If the other insured is not the AHCCCS recipient, enter the month, day, and year (MM/DD/YYYY) of the other insured's birth. Check the appropriate box to indicate gender.

9c. Employer's Name or School Name

Required if applicable

Enter the name of the organization, such as an employer or school, which makes the insurance available to the individual identified in Field 9.

9d. Insurance Plan Name or Program Name

Required if applicable

Rec

Enter name of insurance company or program name that provides the insurance coverage.

10 a - c.

Is Patient's Condition Related to:

Check "YES" or "NO" to indicate whether the patient's condition is related to employment, an auto accident, or other accident. If the patient's condition is the result of an auto accident, enter the two-letter abbreviation of the state in which the person responsible for the accident is insured.

10. IS PATIENT'S CONDITION RELATED TO:										
a. EMPLOYMENT? (CURRENT OR PREVIOUS)										
🗷 YES	□NO									
b. AUTO ACCIDENT?	PLACE (State)									
☐ YES	▼ NO									
c. OTHER ACCIDENT?										
☐ YES	⋈ NO									

September 2008 Fee-For-Service Provider Manual

Billing on the CMS 1500 Claim Form



Page: 5 - 4 Chapter: 5

COMPLETING THE CMS 1500 CLAIM FORM (VERSION 08/05)(CONT.)

10d.	Reserved for Local Use	Not Required
11.	Insured's Group Policy or FECA Number	Required if applicable
11a.	Insured's Date of Birth and Sex	Required if applicable
11b.	Employer's Name or School Name	Required if applicable
11c.	Insurance Plan Name or Program Name	Required if applicable
11d.	Is There Another Health Benefit Plan?	Required if applicable
	Check the appropriate box to indicate coverage other than Alchecked, you must complete Fields 9a-d.	HCCCS. If "Yes" is
12.	Patient or Authorized Person's Signature	Not required
13.	Insured's or Authorized Person's Signature	Not required
14.	Date of Current Illness/Injury or Pregnancy	Required if applicable
15.	Date of Same or Similar Illness	Not required
16.	Dates Patient Unable to Work in Current Occupation	Not required
17.	Name of Referring Provider or Other Source	Required if applicable
17a.	ID Number of Referring Provider (Required on	ly for podiatry services)
17b.	NPI # of Referring Provider (shaded area) (Required only	for podiatry services)
18.	Hospitalization Dates Related to Current Services	Not required
19.	Reserved for Local Use	Not required
20.	Outside Lab? Yes or No and (\$) Charges	Not required



Fee-For-Service Provider Manual

September 2008

Chapter: 5 Page: 5 - 5

COMPLETING THE CMS 1500 CLAIM FORM (VERSION 08/05)(CONT.)

21. Diagnosis Codes

Required

Enter at least one *ICD-9 diagnosis code* describing the recipient's condition. Behavioral health providers must **not** use DSM-4 diagnosis codes. Up to four diagnosis codes in priority order (primary condition, secondary condition, etc.) may be entered.

21 DIAGNOSIS OR NATURE OF ILL NESS OR INITIRY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24F RY LINE)

ı. 250 . 52	3.
2.	4.

22. Medicaid Resubmission Code

Required if applicable

Enter the appropriate code ("A" or "V") to indicate whether this claim is a resubmission of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the AHCCCS Claim Reference Number (CRN) of the denied claim being resubmitted or the paid claim being adjusted or voided in the field labeled "Original Reference No."

See Chapter 4, General Billing Rules, for information on resubmissions, adjustments, and voids.

22 MEDICAID RESURMISSION										
CODE	ORIGINAL REF. NO.									
Α	060010004321									

23. Prior Authorization Number

Not required

The AHCCCS claims system automatically searches for the appropriate authorization for services that require authorization. See Chapter 8, Authorizations/IHS Referrals, for information on prior authorization.

Fee-For-Service Provider Manual

Billing on the CMS 1500 Claim Form

Page: 5 - 6 Chapter: 5



COMPLETING THE CMS 1500 CLAIM FORM (VERSION 08/05)(CONT.)

(24A – I Shaded areas NOT USED)

24A. Date(s) of Service

Required

Enter the beginning and ending service dates.

24.	A					В	С	D		
DATE(S) OF SERVICE						Place		PROCEDURE, SEI	RVICES, OR SUPPLIES	
From To				of	EMG	(Explain U	nusual Circumstances)			
MM	DD	YY	MM	DD	YY	Service		CPT/HCPCS MODIFIER		
02 15 07 02 15 07										

24B. Place of Service Required

Enter the two-digit code that describes the place of service.

03	School	22	Outpatient Hospital	54	ICF/Mentally Retarded
04	Homeless shelter	23	ER – Hospital	55	Residential Substance Abuse
05	IHS Free-standing	24	ASC		Treatment Facility
	Facility	25	Birthing Center	56	Psych Residential Treatment
06	IHS Provider-based	26	Military Treatment Facility		Center
	Facility	31	Skilled Nursing Facility	57	Non-residential Substance
07	Tribal 638 Free-standing	32	Nursing Facility		Abuse Treatment Facility
	Facility	33	Custodial Care Facility	60	Mass Immunization Center
08	Tribal 638 Provider-	34	Hospice	61	Comprehensive Inpatient
	based Facility	41	Ambulance – Land		Rehabilitation Facility
11	Office	42	Ambulance – Air or Water	62	Comprehensive Outpatient
12	Home	49	Independent Clinic		Rehabilitation Facility
13	Assisted Living Facility	50	FQHC	65	ESRD Treatment Facility
14	Group Home	51	Inpatient Psych Facility	71	Public Health Clinic
15	Mobile Unit	52	Psych Facility - Partial	72	Rural Health Clinic
20	Urgent Care Facility		Hospitalization	81	Independent Laboratory
21	Inpatient Hospital	53	Community Mental Health Center	99	Other Place of Service

24.	A					В	С	D		
	DA	TE(S) C	F SER	VICE		Place		PROCEDURE, SERVICES, OR SUPPLIES		
	From To					Of	EMG	(Explain Unusual Circumstances)		
MM	DD	YY	MM	DD	YY	Service		CPT/HCPCS	MODIFIER	
						11				



Fee-For-Service Provider Manual

September 2008

Chapter: 5 Page: 5 - 7

COMPLETING THE CMS 1500 CLAIM FORM (VERSION 08/05)(CONT.)

24C. EMG – Emergency Indicator

Required if applicable

Mark this box with a "✓," an "X," or a "Y" if the service was an emergency service, regardless of where it was provided.

24.	A					В	C		D	
	DA	TE(S) C	F SER	VICE		Place		PROCEDURE, SEF	RVICES, OR SUPPLIES	
	From To					Of	EMG	(Explain Unusual Circumstances)		
MM	DD	YY	MM	DD	YY	Service		CPT/HCPCS	MODIFIER	
							Y			
							1			

24D. Procedures, Services, or Supplies

Required

Enter the CPT or HCPCS procedure code that identifies the service provided. If the same procedure is provided multiple times on the *same date of service*, enter the procedure only once. Use the Units field (Field 24G) to indicate the number of times the service was provided on that date. Unit definitions must be consistent with the HCPCS and CPT manuals.

For some claims billed with CPT/HCPCS codes, procedure modifiers must be used to accurately identify the service provider and avoid delay or denial of payment.

A					В	C	D		
DA'	TE(S) C	F SER	VICE		Place		PROCEDURE, SERVICES, OR SUPPLIES		
From To						EMG	(Explain Unusual Circumstances)		
DD	YY	MM	DD	YY	Service		CPT/HCPCS	MODIFIER	}
							71010	21	
							71010	26	
	DA'	DATE(S) C From	DATE(S) OF SER'	DATE(S) OF SERVICE From To	DATE(S) OF SERVICE From To	DATE(S) OF SERVICE Place From To of	DATE(S) OF SERVICE Place From To of EMG	DATE(S) OF SERVICE From To Of EMG PROCEDURE, SEI (Explain U)	DATE(S) OF SERVICE From To of EMG (Explain Unusual Circuit CPT/HCPCS MODIFIER

AHCCCS Fee-For-Service Provider Manual Updated: 09/02/2008

Fee-For-Service Provider Manual

Billing on the CMS 1500 Claim Form

Page: 5 - 8 Chapter: 5



COMPLETING THE CMS 1500 CLAIM FORM (VERSION 08/05)(CONT.)

24E. Diagnosis Pointer

Required

Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the *number* of the appropriate diagnosis. Enter only the reference number from Field 21 (1, 2, 3, or 4), *not* the diagnosis code itself. If more than one number is entered, they should be in descending order of importance.

D	Е	F	G	Н
RVICES, OR SUPPLIES nusual Circumstances) MODIFIER	DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
	1, 2			

24F. \$ Charges Required

Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units. For example, if each unit is billed at \$50.00 and three units were provided, enter \$150.00 here and three units in Field 24G.

D	Е	F	G	Н
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
		179 00		

24G. Days/Units Required

Enter the units of service provided on the date(s) in Field 24A. Bill all units of service provided on a given date on one line. Unit definitions must be consistent with CPT and HCPCS manuals.

D		Е	F	G	Н
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
CI I/IICI CS	MODIFIER	CODE		UNITS	1 Idii
				1	

Fee-For-Service Provider Manual Billing on the CMS 1500 Claim Form Chapter: 5

September 2008

Page: 5 - 9

COMPLETING THE CMS 1500 CLAIM FORM (VERSION 08/05)(CONT.)

24H. EPSDT/Family Planning

Not required

24I. ID Qualifier

Required if applicable

24J. (SHADED AREA) – Use for COB INFORMATION

Required if applicable

Use this **SHADED** field to report Medicare and/or other insurance information. For Medicare, enter the Coinsurance and Deductible amounts. If a recipient' Deductible has been met, enter zero (0) for the Deductible amount.

For recipients and service covered by a third party payer, enter only the amount paid.

Always attach a copy of the Medicare or other insurer's EOB to the claim.

If the recipient has Medicare coverage but the service is not covered by Medicare or the provider has received no reimbursement from Medicare, the provider should "zero fill" Field 24J (Shaded area). Leaving this field blank will cause the claim to be denied.

See Chapter 9, Medicare/Other Insurance Liability, for details on billing claims with Medicare and other insurance. See example below.

AHCCCS Fee-For-Service Provider Manual Updated: 09/02/2008

Fee-For-Service Provider Manual

Billing on the CMS 1500 Claim Form

Page: 5 - 10 Chapter: 5



COMPLETING THE CMS 1500 CLAIM FORM (VERSION 08/05)(CONT.)

24J. (NON SHADED AREA) – RENDERING PROVIDER ID # Required

Rendering Provider's NPI is required for all providers that are mandated to maintain an NPI #.

For atypical provider types, the AHCCCS ID must be used.

Е	F	G DAYS	H EPSDT	I	J
DIAGNOSIS	\$ CHARGES	OR	Family	ID	RENDERING
POINTER		UNITS	Plan	QUAL	PROVIDER ID#
					COB
					Information
					NPI
					Rendering Provider
					NPI ID#

25. Federal Tax ID Number

Required

Enter the tax ID number and check the box labeled "EIN." If the provider does not have a tax ID, enter the provider's Social Security Number and check the box labeled "SSN."

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NO.
86-1234567		$\overline{\checkmark}$	

26. Patient Account Number

Required if applicable

This is a number that the provider has assigned to uniquely identify this claim in the provider's records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS CRN and the provider's own accounting or tracking system.



Fee-For-Service Provider Manual Billing on the CMS 1500 Claim Form Chapter: 5

September 2008

Page: 5 - 11

COMPLETING THE CMS 1500 CLAIM FORM (VERSION 08/05)(CONT.)

27.	Accept Assignment	Not required				
28.	Total Charge	Req	uired			
	Enter the total for all charges for all lines on the claim.					
	27. ACCEPT ASSIGNMENT? (For govt claims, see back) YES NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE		

29. Amount Paid

Required if applicable

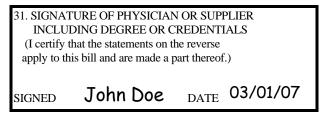
Enter the total amount that the provider has been paid for this claim by all sources *other than AHCCCS*. Do *not* enter any amounts expected to be paid by AHCCCS.

30. Balance Due Not required

31. Signature of Physician or Supplier, including degrees and credentials and Date

Required

The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.



32. Service Facility Location Information

Required if applicable

32a. Service Facility NPI # (non-shaded area)

Required if applicable

AHCCCS Fee-For-Service Provider Manual Updated: 09/02/2008

September 2008

Fee-For-Service Provider Manual

Billing on the CMS 1500 Claim Form

Page: 5 - 12 Chapter: 5



COMPLETING THE CMS 1500 CLAIM FORM (VERSION 08/05)(CONT.)

32b. Service Facility AHCCCS ID # (Shaded Area)

Required if applicable

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

Arizona Hospital

123 Main Street

Scottsdale, AZ 85252

a. NPI | b. AHCCCS ID

33. Billing Provider Name, Address and Phone

Required

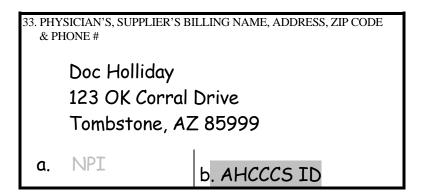
Enter the provider name, address, and phone number. If a group is billing, enter the group biller's name, address, and phone number.

33a. Billing Provider NPI # (non-shaded area)

Required if applicable

33b. Other ID - AHCCCS ID # (Shaded Area)

Required if applicable



** Note – NPI is required for all providers that are mandated to maintain an NPI number.

For atypical provider types, box 33b must be completed.